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Mental health consumers' perceptions of receiving recovery-focused services

Sarah Marshall
smarshal@uow.edu.au

Lindsay G. Oades
University of Wollongong, loades@uow.edu.au

Trevor P. Crowe
University of Wollongong, tcrowe@uow.edu.au

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Abstract

Method: A self-report questionnaire was developed drawing on key aspects of the Collaborative Recovery Model (CRM) (responsibility, collaboration, autonomy, motivation, needs, goals, homework). Ninety-two adult consumers from metropolitan, regional and rural non-government organizations and public mental health services in eastern Australian states completed the questionnaire. Results: Consumers using services provided by CRM trained workers identified significant changes to service delivery in relation to frequency with which they were encouraged to take responsibility for their recovery, degree to which they collaborated with staff and the extent to which they were encouraged to complete homework activities to assist them to achieve their goals, when compared to consumers using traditional services. The key aspects of the CRM were valued by consumers. No differences were found in terms of overall ratings of clinician helpfulness in assisting recovery between the two groups. Conclusions: Consumers are able to perceive recovery-focused service changes. Although preliminary, this is a significant step towards assessing the operationalisation of recovery principles from the consumer's perspective.

Keywords

recovery, mental, health, consumers, perceptions, services, receiving, focused

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Mental health consumers' perceptions of receiving recovery-focused services

Sarah L. Marshall B.Sc,[1] Lindsay G. Oades B.A. (Hons) MBA PhD[2] and Trevor P. Crowe B.Sc. PhD[3]

[1]Research Assistant, [2]Senior Lecturer, [3]Research Fellow, Illawarra Institute for Mental Health, Building 22 University of Wollongong, Wollongong, New South Wales, Australia

Keywords
case management, consumers, evaluation, mental health services, recovery, user

Correspondence
Sarah Marshall
Illawarra Institute for Mental Health
Building 22
University of Wollongong
Wollongong
NSW 2522
Australia
E-mail: sarahmarshall600@hotmail.com

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Abstract

Rationale, aims and objectives This study examines the experiences of mental health service consumers engaged in various recovery-focused support practices as well as examining consumer valuing of these activities.

Method A self-report questionnaire was developed drawing on key aspects of the Collaborative Recovery Model (CRM) (responsibility, collaboration, autonomy, motivation, needs, goals, homework). Ninety-two adult consumers from metropolitan, regional and rural non-government organizations and public mental health services in eastern Australian states completed the questionnaire.

Results Consumers using services provided by CRM-trained workers identified significant changes to service delivery in relation to frequency with which they were encouraged to take responsibility for their recovery, degree to which they collaborated with staff and the extent to which they were encouraged to complete homework activities to assist them to achieve their goals, when compared with consumers using traditional services. The key aspects of the CRM were valued by consumers. No differences were found in terms of overall ratings of clinician helpfulness in assisting recovery between the two groups.

Conclusions Consumers are able to perceive recovery-focused service changes. Although preliminary, this is a significant step towards assessing the operationalization of recovery principles from the consumer's perspective.

Introduction

For several years recovery has been rising to the forefront as a guiding vision for mental health services internationally [1,2] and in Australia [3]. Consumer participation has also increasingly come to be valued within mental health policy across all aspects of mental health services, including evaluation [2–4]. However, a recent review identified that consumers have infrequently been involved in case management evaluation and have rarely been asked about recovery-focused practices within case management settings [5]. This is apparent both in terms of consumers' perceptions of the support activities they engage in within case management settings, as well as how they feel about these service contact experiences. This study begins to address this research gap through an evaluation of consumers' perceptions of a recovery focused approach to case management, known as the Collaborative Recovery Model (CRM) [6].

The term 'case management' is used broadly in this study to refer to the coordination of care of people with mental illness living in the community [7]. The term is therefore inclusive of consumers accessing services from both public mental health services, as well as non-government organizations involved in this study.

The CRM incorporates both evidence-based practices in mental health settings, with broader evidence consistent with psychological recovery [8]. Specifically, the CRM emphasizes the research evidence regarding the relationship between working alliance and outcomes [9], motivational enhancement [10], relationship between goals and well-being [11] and the effect of homework on outcomes [12]. The CRM also emphasizes the importance of hope, autonomy, self-determination and consumer participation, which feature in the recovery literature [6]. The major components of the CRM include two guiding principles 'recovery as an individual process' [8], and 'collaboration and autonomy support' [13], and four skills-based components: (1) change enhancement [14]; (2) collaborative needs identification [15]; (3) collaborative goal striving [16]; and (4) collaborative task striving and monitoring [17]. The Collaborative Recovery Training Program for mental health staff consists of a 2-day training workshop, followed by two 1-day booster sessions at 6 and 12 months following initial training [18].

For further description of the CRM and associated training programme see Oades *et al.* [6].

While there is evidence regarding the usefulness of the specific aspects of the CRM, as discussed above few studies have examined how important these case management activities are from consumers' perspectives. For example, while homework or action planning is recommended for use with people with severe mental illness [17] the authors are only aware of one small study [19] where 10 consumers with a history of psychosis were asked about their experiences of homework-based activities. However, this previous study focused on exploring reasons for 'homework compliance', rather than more general evaluation regarding experiences and valuing of these activities. Furthermore, there is evidence that motivational interviewing is effective in assisting people to clarify both benefits and barriers to individual goals [14], and that meeting specific consumer needs is associated with reduction in symptoms and improved quality of life [20]. Little is known, however, of the perceived importance from a consumer perspective regarding needs-based assessment and motivational enhancement.

When compared with the views of mental health professionals, there is more known at present about consumer perspectives highlighting the importance of collaborative practices [21–23], responsibility for recovery [22] and goal striving activities [22,24]. There is clearly a need, however, to further examine consumers' perceptions regarding the relevance and importance of *all* CRM aspects when working with mental health staff within case management contexts.

This study involves the development and utilization of a self-report questionnaire to explore consumers' perceptions regarding engaging in recovery-focused practice in mental health services for consumers working with CRM-trained workers in comparison to non-CRM-trained workers.

Specifically it is proposed that:

1 Consumer ratings of frequency with which they engage in key aspects of recovery focused care will be higher for consumers working with CRM-trained case managers.

2 Consumer ratings of case managers' overall helpfulness in assisting recovery will be higher for consumers working with CRM-trained case managers.

Method

Materials-Development of the Consumer Evaluation of Collaborative Recovery Model

The self-report questionnaire, the Consumer Evaluation of the Collaborative Recovery Model (or CEO-CRM), was developed by researchers from the Illawarra Institute for Mental Health, University of Wollongong. Fourteen questionnaire items were generated, which attempted to assess key guiding principles and components of the CRM approach (i.e. responsibility, collaboration, autonomy, motivation, needs, goals, homework). The CEO-CRM asked people to: (1) rate the frequency with which they engaged in key aspects of the CRM over the previous 3-month period (scale ranged from 0 = 'never' to 4 = 'always', 7 items); (2) rate the 'importance' they placed on key aspects of the CRM in relation to assisting individuals' recovery processes (scale ranged from 0 = 'not important' to 4 = 'extremely important', 7 items); and (3) provide a rating of case managers' 'overall helpfulness' in relation to assisting individuals' recovery processes over the previous 3 month period (scale ranged from −3 = 'extremely unhelpful' to 3 = 'extremely helpful', one item). The introduction to the CEO-CRM specified the following definition of recovery to provide clarification of usage of this term relevant to this study: 'Psychological recovery can be defined as a process whereby individuals acquire hope and self determination to lead a meaningful life and achieve a positive sense of self, whether or not mental illness is still present' [8].

There was an intentional focus on keeping CEO-CRM items easy to understand for a wide range of participants. Five consumers from the Illawarra/Shoalhaven region in New South Wales provided feedback on readability and acceptability. All had been involved in previous research and/or worked as consumer consultants in the mental health field. Recommendations included minor changes to spacing and layout and informed refinement of the measure. Reliability of the CEO-CRM was tested and was found to be acceptable for a developing measure (Cronbach's alpha of 0.78 for 'importance items' and 0.80 for 'frequency items'). Item-total correlations suggested that the measure was internally consistent, with Cronbach's alphas ranging between 0.410 and 0.696 for the 7 frequency items and 0.439 and 0.680 for the 7 importance items.

Sample

Participants taking part in this research were involved in a larger project entitled the Australian Integrated Mental Health Initiative High Support Stream Study (AIMhi HSS) [18]. Inclusion criteria included a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder or Major Depressive Disorder with psychotic features of at least 6-month duration and high support needs (identified as five or more total needs using the Camberwell Assessment of Need Short Appraisal Schedule). Individuals with dementia, severe mental retardation or brain injury were excluded [6].

A total of 92 consumers, taking part in the AIMhi HSS project from a total of three different public mental health services and four non-government organizations in three eastern states of Australia, completed questionnaires. This included metropolitan, regional, as well as rural locations. Mental health services participating in the AIMhi HSS project were randomized by organization to either an immediate or 1 year delayed CRM training condition. As part of this study questionnaires were collected from as many consumers as possible participating in the AIMhi HSS project, within the limitations of time and resources. Out of a potential sample of approximately $n = 190$ consumers taking part in the AIMhi HSS project, a convenience sample of $n = 92$ (48%) took part in this study.

Of the 92 consumer participants 47 were male, 30 were female and gender information was missing for 15 participants. The mean age of consumer participants was 42.5 years with a SD of 10.2 years. Consumers in delayed and active conditions did not differ significantly on demographic variables of sex ($\chi^2 = 2.9$, $P = 0.09$) or age ($F = 0.41$, $P = 0.53$). The majority of participants (68%) met a diagnosis for schizophrenia (consistent with sampling for the AIMhi HSS study), with the remaining participants meeting a diagnosis for schizoaffective disorder (8%), bipolar (6%), depressive psychosis (8%) or dual disorder (10%).

Table 1 Consumer's frequency ratings for responsibility, collaboration, homework and goal striving by delayed and active conditions

Area explored	Specific aspect of CRM	Delayed mean ($n = 45$)	SD	Active mean ($n = 47$)	SD	*Z* score
Frequency	Responsibility	3.13	1.22	3.67	0.56	–1.91*
	Collaboration	3.13	1.02	3.58	0.66	–2.16**
	Homework	2.34	1.41	3.24	0.93	–3.13***
	Goal striving	3.12	1.02	3.44	0.72	–1.39†

*$P < 0.05$; **$P < 0.01$; ***$P < 0.001$.
†Goal striving approached significance, $P = 0.08$.

Service characteristic information was collected using the Dartmouth Assertive Community Treatment Scale [25]. Staff working with consumers taking part in this study had an average caseload of 10 clients or less, spent an average of 85–119 minutes with each client per week and had an average of 2–3 contacts with each client per week. While these averages appear high, 58% of participants were attending community-based non-government organizations. Average caseload, service intensity and frequency information were compared for staff working with consumer participants in delayed and active conditions. Consumers in the delayed condition were found to be working with case managers with significantly smaller caseloads when compared with case managers in the active condition ($Z = -1.9$, $P = 0.05$). Service intensity and frequency did not differ between delayed and active conditions.

Data collection

Research assistants distributed and collected the questionnaire (including consumer research assistant in some sites). Collection of the CEO-CRM for consumers in the active condition occurred 6 months post CRM training. In the delayed condition the questionnaire was completed at any time, prior to training for mental health staff.

Analyses

Normality of data was examined using Kolmogorov-Smirnov statistic. Tests were significant and indicated that data were positively skewed. Therefore, only non-parametric analyses were undertaken. The Mann–Whitney *U*-test was run to compare ratings of 'frequency', 'importance' and 'overall helpfulness' for consumers in delayed and active conditions.

Results

Differences in frequency ratings between delayed and active conditions

Consumers in the active condition reported that their case managers encouraged them to take responsibility for their recovery ($Z = -1.91$, $P = 0.03$), collaborated with them ($Z = -2.16$, $P = 0.02$) and encouraged them to complete homework activities to assist them to achieve their goals ($Z = -3.13$, $P = 0.00$) significantly more often than consumers in the delayed condition. In addition, findings approached significance for goal striving ($Z = -1.39$, $P = 0.08$) (see Table 1). No significant differences were found for frequency ratings between the two groups for the remaining CRM components of autonomy support, motivational enhancement and needs assessment.

Consumers' valuation of practices consistent with Collaborative Recovery approach

Mean importance ratings and SD for all items are reported in Table 2. Percentage of consumer participants rating each CRM aspect as 'unimportant' (determined by a score of '0' or '1' on the rating scale) is also reported. On average, it was found that the vast majority of consumers tended to rate all aspects of the CRM as important in terms of assisting their recovery.

For the practical aspect of homework striving, a considerably higher number of participants rated this area as 'unimportant', when compared with all other areas. However, this percentage (11%) was still relatively low, when compared with the overall sample. All participants rating homework as 'unimportant' were in the delayed condition.

Friedman's test was conducted to establish whether homework importance was rated significantly below other CRM practices for consumer participants in the delayed condition. Friedman's test indicated that differences were significant ($\chi^2 = 25.1$, d.f. = 6, $P < 0.00$). Wilcoxon Signed Ranks test indicated which aspects of the CRM were comparatively viewed as significantly more important by consumers. As anticipated homework was found to be contributing to the majority of the variance and was rated significantly *below* all other areas of the CRM in terms of perceived importance for consumers in the delayed condition, with the exception of the autonomy item ('my case manager respects my right not to take his/her advice', $Z = -1.83$, $P = 0.07$). In contrast, Friedman's test was non-significant for consumers in the active condition ($\chi^2 = 7.63$, d.f. = 6, $P = 0.27$). That is, consumers working with CRM-trained staff appeared to value all aspects of the CRM to a similar degree.

Overall helpfulness ratings

The Mann–Whitney *U*-test was used to compare consumers' ratings of case managers 'overall helpfulness' in assisting recovery between delayed and active conditions. Ratings of 'overall helpfulness' in assisting recovery over the previous 3-month period were non-significant between delayed (M = 2.24, SD = 1.30) and active (M = 2.49, SD = 0.86) conditions ($Z = -0.79$, $P = 0.43$). In general consumers were found to rate case managers as helpful in assisting their recovery, regardless of condition. Only three people (7%) in the delayed condition rated their workers as 'unhelpful' in assisting their recovery over the previous 3-month period (defined

Table 2 Consumers' importance ratings for CRM guiding principles and components

Questionnaire item	Mean importance	SD	Percentage of consumers rating area as 'unimportant'*
My case manager encourages me to take responsibility for my own recovery process	3.41	0.86	(3%)
My case manager involves me in decisions about my recovery process	3.46	0.78	(2%)
My case manager respects my right not to take his/her advice	3.14	0.92	(3%)
My case manager helps to motivate me	3.45	0.79	(3%)
My case manager understands my range of needs	3.36	0.82	(5%)
My case manager encourages me to set goals that are meaningful for me	3.38	0.86	(5%)
My case manager encourages me to set homework tasks to achieve my own goals	3.07	1.19	(11%)

*Ratings indicating lack of importance for particular items were determined by a score of 0 or 1 on the rating scale.

as a negative rating), compared with no consumers in the active condition.

Discussion

While preliminary reliability and face validity of the CEO-CRM measure was demonstrated, further piloting and psychometric testing of this measure is necessary in the future. Despite this caution, this study is significant as it is an early attempt to 'measure' the extent to which various recovery-based practices are being engaged in within mental health service settings from the perspective of mental health consumers.

Preliminary findings suggest that consumers were able to identify significant changes to service delivery in relation to the frequency with which they were encouraged to take responsibility for recovery, degree with which they collaborated with their worker and completed homework activities. This is particularly noteworthy considering that consumers in the delayed condition were working with case managers with significantly smaller caseloads on average, when compared with case managers in the active condition. Regardless, findings were significant in the expected direction. These findings are also promising considering the difficulties related to ensuring that new mental health interventions are implemented in services [26,27].

Perceived frequency of homework completion was significantly higher after case managers had completed CRM training. Consistent with existing research this suggests that without specific training case managers are less likely to use homework systematically [17,28]. A recent study of 122 case managers in public and non-government mental health organizations in Australia found that only 15% of workers used a systematic approach to homework administration [17]. This is comparable with a New Zealand study which found that only 25% of psychologists surveyed completed homework systematically [28]. Therefore, at least in terms of consumer perceptions it is possible that CRM training for mental health staff may have led to more frequent homework administration procedures.

It is also possible that CRM training may have positively influenced staff attitudes towards homework, in turn leading to an increase in frequency of homework activities for staff and consumers. Findings from a recent study indicate that case managers who held positive attitudes towards homework were more likely to report higher levels of homework completion and also better response from clients and quality of homework completion [29], lending some support to this possibility.

It is possible that goal setting in comparison may already be a more routine clinical practice, making it harder to identify differences between conditions, as observed in this study. A recent study demonstrates, however, that training in CRM does lead to a significant improvement in goal setting quality by mental health workers (S. Clarke *et al.*, Unpublished). Another possible explanation is that goal setting, as emphasized within CRM training is to be completed much less frequently (at 3-month intervals), when compared with the homework component (emphasis on fortnightly completion), reducing the likelihood of detecting changes in frequency around completion of this component.

The vast majority of consumers appeared to value ways of working emphasized within the CRM approach, whether they had been working in these ways or not. These findings are particularly important as limited evidence exists at present from consumers' perspectives, to support many of these ways of working (see p. 655). It was found that consumers in the delayed condition (working with staff delivering services as usual) placed less importance on homework activities, when compared with all other aspects of the CRM approach (excluding autonomy support). In contrast, no differences for importance ratings of CRM aspects were found for consumers in the active condition. It may be that as consumers in the AIMhi HSS project appeared to be completing homework more often that they were more likely to see the value in it. Alternatively, it is possible that consumers in the active condition placed more value on homework because it was completed more systematically and was clearly linked to helping them achieve their goals. This possibility is tentative and requires further examination through direct querying of mental health consumers.

Consumers working with CRM-trained case managers did not rate their workers as more helpful in supporting recovery. However, frequency ratings with which consumers worked consistently with the CRM were skewed in the positive direction, for participants in

delayed and active conditions, which may suggest a ceiling effect operating, or that 'overall helpfulness' may be perceived as independent from the frequency of specific activities. Another possible interpretation is that consumers in the delayed condition may have overrated their experiences in a positive manner, based on their inability to envisage alternate, more helpful ways of working. Furthermore, it is possible that consumers may have responded in a socially desirable way to the CEO-CRM, despite attempts to reduce this likelihood through reinforcing confidentiality and involving outside researchers (rather than direct service staff) in data collection. Clearly ratings of overall helpfulness do not specifically address whether consumers perceived the CRM to be *more* helpful in assisting their recovery, when compared with receiving services as normal in case management contexts.

The current finding that consumers viewed workers as generally supportive of their recovery journey is inconsistent with findings of some researchers [22,30]. For example, Tooth *et al.* [30] found that two-thirds of the 57 people they interviewed as part of their Australian study reported that 'health professionals' had a negative impact on their recovery. However, it is unclear as to the nature of services and staff discussed within this study (e.g. crisis and hospital-based services, public mental health services, etc). In a US study involving 115 consumers, researchers found reports of much more 'hindering' content in relation to formal mental health services and staff employed within it, than in any other domain [22]. This included consumer feedback on a range of services including, but not limited to crisis oriented and emergency services. Differences in this study may be explained in that crisis and emergency services are by their very nature more illness focused and less likely to be oriented towards broader recovery [22]. The Attitudes of Health Professionals Project undertaken in Australia indicated that consumers' satisfaction with public and private psychiatric hospitals was lowest, when compared with various other aspects of mental health service delivery [31].

A clear limitation of this study is that it utilizes a questionnaire that requires further psychometric testing in order to more extensively establish its validity and reliability. Therefore, results are reported as preliminary and must be interpreted with caution. Another limitation of this study is that consumers were only able to provide limited feedback about the services they received by way of structured item ratings. This methodology clearly limits consumers' ability to comment in any detail about the services they received and to identify any difficulties or concerns. It also does not allow consumers to discuss any ideas that they may have for improving service delivery. Future research in this area should, where possible, provide consumers with the opportunity to comment about their experiences of case management services through a range of methodologies, including open-ended questioning [5]. Qualitative methodologies are likely to be particularly important when generating information about processes, which can drive service delivery improvement [32]. Researchers in this study are currently conducting further evaluation regarding consumers' experiences of receiving the CRM in services, by way of face-to-face interviews and focus group studies.

Conclusions

Preliminary findings suggest that consumers were able to identify some significant changes to service delivery in terms of the frequency with which they were encouraged to take responsibility for recovery, degree with which they collaborated with their workers and the extent to which they completed homework activities to assist them to achieve their own goals, within case management settings. It was also found that the vast majority of consumers appeared to value, or place importance on key aspects of the CRM when working with staff, regardless of whether they had been working in these ways or not. Consumers reported that staff members were generally supportive of their recovery process, irrespective of whether their workers had received CRM training. This study is noteworthy as it is one of few known attempts to evaluate the degree to which a recovery-oriented approach to service delivery has been transferred at the level of service delivery, from the perspective of mental health consumers. It also examines consumers valuing of key aspects of this particular approach to delivering recovery-oriented services. Clearly this is an important direction for future research if the emphasis on recovery oriented mental health services is to be realized.

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